Iowa Department of Human Services
Mental Health and Disability Service System Redesign
Mental Health Workgroup
October 18, 2011

Briefing Paper

Part I: Summary of Recommendations to Date
Part II: Rebalancing Mental Health Systems

Part I: **DRAFT Recommendations from Mental Health Workgroup**:

1. Eligibility:

The Workgroup recommends the following criteria for general eligibility for mental health services in the State of Iowa. Other insurance coverage (e.g. Medicaid, Medicare, other third party) will have unique eligibility criteria. In addition, people will receive specific services depending on certain criteria including level of functioning, severity of symptoms and other needs, and by funding source (i.e. federal block grant).

Age: An individual must be 18 years or older.

Residency: An individual must be a Resident of the State of Iowa.

Financial Eligibility: An individual must have an income equal to or less than one hundred fifty percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human services. A contracted provider shall apply a copayment requirement for a particular disability service to a person with an income equal to or less than one hundred fifty percent of the federal poverty level. The copayment amount shall be established with rules adopted by the commission applying uniform standards with respect to copayment requirements. A person with an income above one hundred fifty percent of the federal poverty level may be eligible subject to a copayment or other cost-sharing arrangement subject to limitations adopted in rule by the commission. A person who is eligible for services must apply for and utilize other potential sources of insurance or financial coverage for services prior to using public funds. Beginning July 1, 2014, savings resulting from the Affordable Care Act's expansion of Medicaid and private insurance to currently uninsured individuals shall be reinvested to expand eligibility to 200% of the Federal Poverty Level.

Diagnosis: An individual must have or have had at any time during the past year a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. An individual will also be eligible for services in situations where criteria for a specific diagnosis have not yet been met, but the individual is experiencing functional impairment and psychological duress which substantially interferes with or limits one or more major life activities. A functional assessment must be documented in the clinical record.

Note: The Workgroup felt that having two definitions in the Iowa code – Mental Illness and Chronic Mental Illness – were unnecessary. The definition of mental illness, as described above in "Diagnosis," and level of impairment should determine general eligibility, and clinical assessment and consumer choice should factor into eligibility for specific services rather that meeting a definition of "chronic mental illness."

Continuity of Services: It is expected that individuals will progress through treatment and services. However, consumer preference and clinical assessment shall be considered in determining the appropriate programs and services available to an individual so as not to jeopardize the recovery of a consumer through premature discharge or termination.

Following the Workgroup meeting on 9/20/11, a subcommittee met to discuss functional assessments. The sub-committee recommends to the Workgroup that a standardized functional assessment tool, such as the LOCUS, be used by all contracted providers who receive Medicaid and non-Medicaid funds for individuals needing an intensity of services beyond Outpatient treatment. Data from the functional assessment shall be submitted to the Regional entity responsible for managing service provision and payment for services. The purpose of the standardized assessment includes the following:

- The tool can be used as an authorization for services to support the recommendation for a particular service. The Regional entity can verify that an assessment has been done and that the service a consumer is receiving or assigned to is consistent with the level of care identified in the assessment. For example, the tool may indicate a level of service equivalent to Outpatient Counseling. Thus,

placement into Assertive Community Treatment (ACT) would be inappropriate and better utilized by a person in need of that level of service, unless a more detailed clinical assessment justifies the need for the more intensive level of care. An individual who is benefitting from a particular program or service should be considered for continued stay in the program or service despite the tool's recommendation if consumer preference and clinical assessment justify continued stay.

- Aggregate data collected from the report can be used in a Dashboard Report to support outcomes. For example, progress or regression can be identified over time on an individual, regional, and a statewide systems level.
- At a state level, aggregate functional assessment data would allow for analyses of levels of service across regions vs. expected need.
- Aggregate data can be used to inform policy makers and payers regarding the general need for particular levels of services. For example, if a region didn't have access to an ACT team, it would be expected that there would be more discrepancies between the LOCUS recommended and actual levels of care, with more patients being in residential settings. This would help support the development adequate array of services to match the needs in each region.

The tool should be administered at set intervals, and more frequently as needed to support clinical decision making for levels of care.

2. Outcomes and Performance Measures:

The workgroup felt strongly that outcomes should be clear and understandable to a wide variety of audiences. The Iowa Plan contractor and regional entities should be required to monitor and evaluate similar outcomes and performance indicators.

Recommendation: The group suggested that outcomes be measured in critical areas such as the following core service domains:

- Acute Care and Crisis Intervention Services
- Mental Health Treatment
- Mental Health Prevention
- Community Living
- Employment

- Recovery Supports
- Family Supports
- Health and Primary Care Services
- Justice Involved Services
- Workforce Development[1]

Data collection must be tied to outcomes. Data must also have relevance to each of the players in the system, including the Department, the Medicaid contractor and the Regional Entities. The workgroup noted that much data is collected in the system, but the general consensus is that it is not used to guide decision making. Contributing to this is the lack of capacity at DHS due to relatively small numbers of staff. There was discussion regarding whether data for performance indicators should be handled by DHS or by the Iowa Plan contractor and regions. A singular repository at the State level is desirable. DHS currently is able to access data about Medicaid recipients. Ability to access similar data about non-Medicaid services including but not limited to dashboard reports is also necessary to provide clarity of services delivered in the state as a whole.

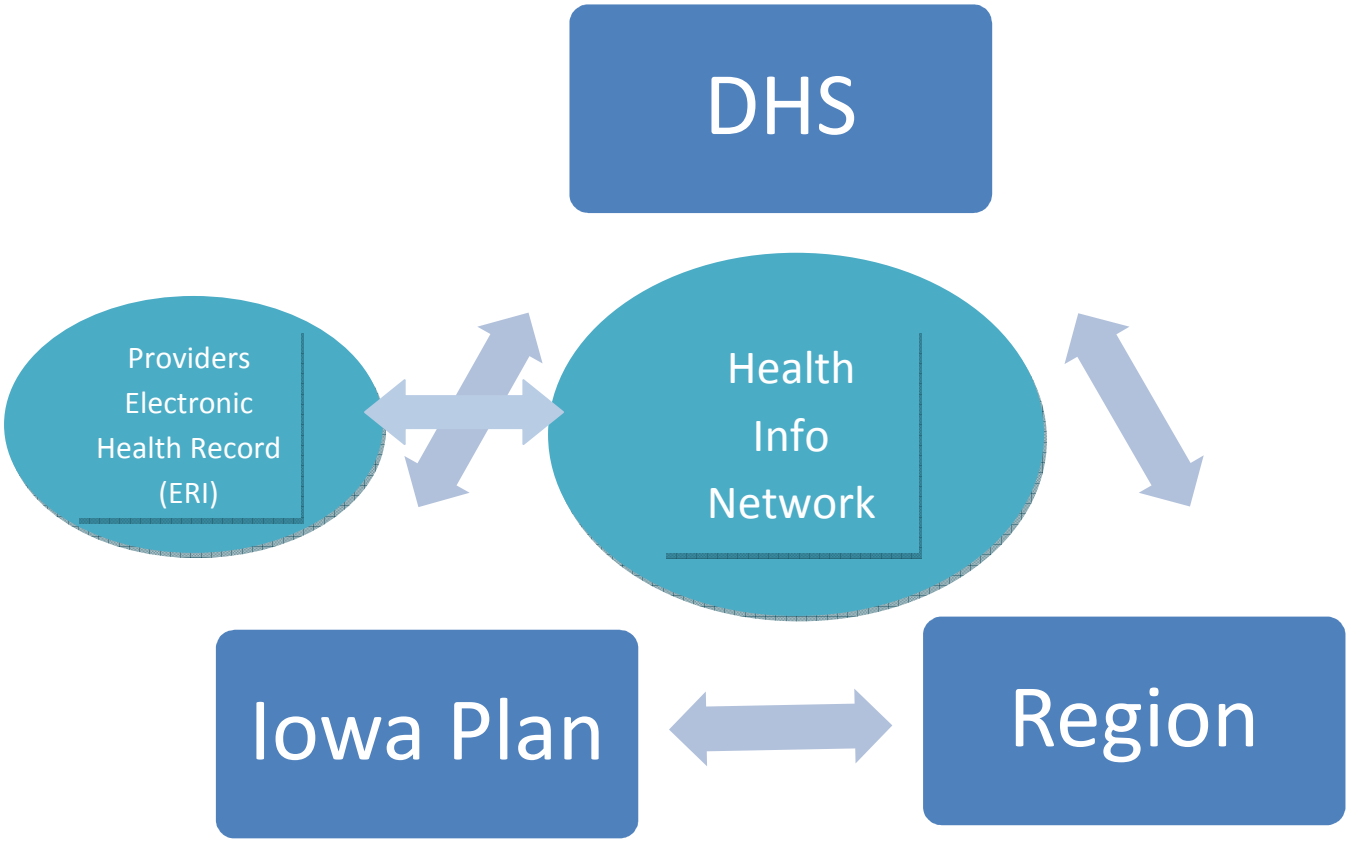
[1] Workforce Development was added to the Outcomes list because of the serious workforce issues confronting Iowa.

The following diagram below demonstrates the interaction of data. An Iowa Health Information Network (IHIN) is currently under development state wide and will serve as Iowa's Health Information Exchange. While Electronic Health Records (EHR) are currently being adopted across health care systems, full implementation is still several years away. However, EHR's alone are not enough without the ability to aggregate and analyze the data. Therefore, HER's should connect to the IHIN.

Any current or future state or regional IT systems (for example the current ISAC system) should also connect to the IHIN. A web-based system at the regional and provider level should also be developed that can support the seamless input and output of data through the IHIN. Data planning efforts need to incorporate HIPAA transaction standards and ICD-10 coding. This will ensure that data collection and coding are consistent and thus provide the ability to extract meaningful information.

A basic diagram for an integrated data delivery system is provided below and demonstrates that when an integrated electronic IHIN is developed with other electronic data feeding into that system, each of the component parts of a system can extract and utilize the data for its purposes.

Integrated Data Diagram:



Recommendation: The Workgroup further recommends that an Outcomes and Performance Measures Committee be established to continue and finalize this work beyond the Redesign process.

The first responsibility of the committee should be to recommend specific outcomes and performance measures to be measured across the system. To the extent possible, there should be consistency across disability groups. This Committee should also include an evaluation of current data collection requirements that should be eliminated because they may be administratively burdensome or have little relevance to outcomes or other reporting requirements (e.g. legislature, federal block grants). A summary of the various data elements that are currently captured by DHS or other entities is attached.

The committee should be composed of DHS employees and stakeholders with expertise in quality improvement, including Magellan, the Olmstead workgroup, University of Iowa, consumers and family members.

Once the outcome and performance measures are established, the MHDS Commission and Department should monitor, evaluate and report the progress toward system outcomes on at least an annual basis as well as any recommendations for improvement or modification.

3. Core Services:

The Workgroup identified a broad list of services and programs that are important to meeting the needs of consumers and families, and that each region must ensure that evidence-based services within each of the following Core Service Domains.

Recommendation: The Core Service Domains identified by the Workgroup that shall be available in each region include:

- Acute Care and Crisis Intervention Services
- Mental Health Treatment
- Mental Health Prevention
- Community Living
- Employment
- Recovery Supports
- Family Supports
- Health and Primary Care Services
- Justice Involved Services

Regarding services, there are more traditional core services such as Outpatient Counseling or Medication Management that are necessary, but there are also other services that are as important to an individual's recovery, nonetheless. These may include, for example, things like rental assistance, transportation, or homemaker services. The critical concept is that a successful system ensures that there is a foundation of core, evidence-based services and programs that deliver a cadre of flexible, individualized services.

The Workgroup recommends that each region shall ensure that evidence-based services within Core Service Domains are available. Within each Domain are specific Core Services that should be available through regional services and the Iowa Plan. Some of these services are specific services, such as Medication Management, while others are programmatic in organization, such as IPPT, and deliver a range of care management and treatment services.

Furthermore, there are some services that are not covered by Medicaid due to program requirements, but nevertheless, are important. For instance, in a Community Support Services model, a service or function such as rental assistance or paying for food on an emergency basis may not be covered by Medicaid, but are worthy of reimbursement as compared with costly alternatives (e.g. homelessness). Therefore, Regions should have the flexibility to pay non-mandatory, yet essential, "services" as needed. Rather than include or exclude specific services that should be considered as reimbursable, the workgroup suggests that the following criteria be considered by regions when reimbursing for services:

1. A person-centered planning process should be utilized to justify the need for particular services, and
2. The services should be recognized as having an evidence-base to support them.
3. Conversely, regions should move away from reimbursing services that do not have a research base that supports improved outcomes or are inconsistent with Olmstead principles.

Recommendation: The Workgroup felt that moving toward the availability of statewide evidence–based practices and away from services that do not have a strong evidence base. This is consistent with Olmstead principles, serving people in the most integrated settings possible, will have the greatest return on investment, and enable the State to rebalance or reallocate funds. This includes the recognition of serving people in smaller, non-congregate care settings and leveraging Medicaid to the extent possible. This process will take time, and, ultimately, financial incentives should be built into rates or contracts to force this transition.

Accordingly, the Workgroup recommends that as regions are developed, they demonstrate a business plan for how they will implement core services in each of the Domains over a five year period. The Workgroup felt this should be developed at a regional level due to the variability in regional makeup. Regional phase---in schedules should demonstrate how services that will yield the greatest return on investment will be phased in earlier in the process.

Recommendation: As part of the discussions on core services, specific services were discussed. In addition to the development of a continuum of available, flexible services in each region, the Workgroup recommends the following services be created in each region. Each service should be capable of working with individuals who present with multi-occurring disabilities and those with more specialized needs (e.g. older adults).

Peer Delivered Services: The use of peers in delivering services is recognized as an evidence-based practice in producing positive outcomes for consumers, and has a secondary gain of expanding the workforce necessary to meet the demand. Each region should establish one or more self-help centers. The self-help centers should be managed by a Consumer Program Manager at a gainful salary. The self-help center should consist of a governance structure that is composed of more than 50% consumers. The self-help center should also build in wellness and supported employment functions to the extent possible. Further, peers should be hired in each of the different programs supported by Medicaid and non-Medicaid funds.

Crisis Services: Each region should have Psychiatric Emergency Screening (PES) services that contain a range of crisis intervention and diversion services. PES services can be organized and administered by a single provider within a region or through a coordinated network of crisis response services as long as the core functions exist. The Acute Care Task Force Report (February 2010) contains models that should be referenced for program development.

- 24/7/365 crisis hotline. The hotline should be answered locally within a region. However, for ease of access to the general public, a single hotline number can be established that automatically bumps to the local area code that the individual in crisis is calling from so that it is answered by PES in close proximity to the caller.

- Mobile Response: The PES must have 24/7/365 mobile response with the goals of, first, mitigating the crisis and diverting from inpatient hospitalization; second, facilitating inpatient hospitalization when civil commitment is necessary; and, third, ensuring linkage with the appropriate follow-up services. Mobile Response may be initiated by PES when a person calls, or may be requested by local police. In situations where Mobile Response is unavailable, a person may go to or be brought to the PES program

for evaluation. The PES program should have capacity and/or access in the local emergency room, as well as, in non-hospital based settings.

- Crisis Residential: Each region should have short-term (0-7 days) crisis residential capacity in an unlocked setting. The purpose of this voluntary program is to help a person stabilize a psychiatric crisis and to avoid an unnecessary inpatient stay. Crisis residential programs may be staffed with consumers. Crisis Residential is for people who are experiencing an acute episode such that if this intervention is not in place, they would otherwise meet inpatient civil commitment criteria. Crisis Residential services may be provided in a person's place of residence with intensive on-site, wraparound support or in a residence designed for this purpose. The residence should serve less than six people at any given point in time. If not directly managed by the PES program, it should work closely with the Crisis Residential program to ensure the efficient use of the beds. DHS should establish standards for Crisis Residential to ensure consistency across the State.

- Facilitate civil commitment process and inpatient treatment when necessary.

Sub-acute Services: The Workgroup felt that a range of sub-acute residential services should be available in each region. Sub-acute services should be defined as a residentially based service, either a) in the person's home, or b) in another residential setting. Sub-acute services have the ability to provide up to 24 hour on-site support with a range of psychiatric and medical treatment and support services. Eligible consumers should not require inpatient care, but their level of functioning is such that they require more intensive supports to remain in the community. Sub-acute services are intended to be temporary in nature with average length of stays up to thirty days with longer lengths of stay requiring authorization from the region. Sub-acute services are ideally in settings with fewer than six people. The Acute Care Task Force Report (February 2010) contains models that should be referenced for program development. However, the Workgroup did not reach consensus as to whether sub-acute facilities should have the ability to be locked or unlocked facilities. DHS should establish standards for Crisis Residential to ensure consistency across the State.

Jail Diversion: Each county within a region should have access to a Jail Diversion program, such as a Crisis Intervention Team (CIT) based upon the principles in the Memphis, Tennessee CIT model. Several programs were studied for best practices including the jail diversion program in Bexar County, Texas as well as the program in Blackhawk County, Iowa. DHS should lead development of jail diversion in coordination with the Department of Corrections, local law enforcement and other stakeholders (e.g. Judiciary, consumer, NAMI). Using the Sequential Intercept Model, which is currently being used in Polk County, Iowa, jail diversion services should assist along the various points of intersection with the criminal justice system.

Assertive Community Treatment (ACT): Each region should have at least one ACT team that can serve Medicaid and non-Medicaid eligible individuals. Regulations that define the scope of ACT services should be established by DHS to ensure consistency throughout the state and fidelity to the ACT model.

Community Support Services/Supportive Housing/Supportive Community Living/Case Management: DHS should blend and consolidate these services into a single service that provides an array of flexible, recovery-oriented support and care/case management services delivered by a team of professionals, paraprofessionals and consumers. By consolidating these services, duplicative, fragmented and competing services can be eliminated in lieu of a more coordinated approach to delivering services. Supporting an individual in their own residence, whether it is with family, a small shared living residence or their own home/apartment is cost effective, consistent with Olmstead, and desired by consumers. In this program, housing is not contingent upon receipt or compliance with services. This model often meets the needs of consumers who are very independent and those who are often difficult to serve in group settings, but can succeed in community living arrangements with intensive wraparound supports. DHS should establish standards for a Community Support Service/Supportive Housing service to ensure a level of consistency throughout Iowa.

Health Homes: Section 2703 gives states the ability to submit a State Plan Amendment to create Health Homes. CMS will pay for 90% of the costs of care management for the first two years. The Iowa Medicaid Enterprise (IME) should submit a SPA to develop Health Homes in each region of the state for the top 5% of high cost utilizers of psychiatric and medical services. Health Homes should be available to Medicaid and non-Medicaid individuals who fall into this category. Magellan currently has an integrated health home pilot underway and IME is in the process of developing a health home SPA.

Supported Employment and Supported Education: Obtaining gainful, meaningful employment is critical to a person's recovery and enables individuals to contribute to the system. Each region should establish these programs, and mechanisms to coordinate with the Iowa Departments of Labor and Education, and at the local level with employers, colleges and universities, should be established. The Workgroup did not recognize sheltered workshops as Supported Employment.

Family Support Services: Family psycho-education is considered a best practice. Regions should create mechanisms for families to receive support, skill building training and other supports to help cope with the illness of their loved one and to assist in their recovery.

Part II: Rebalancing Mental Health Systems:

Mental health systems across the country have historically been built upon an institutional, "get sick first" foundation. In the 19th century, many large state psychiatric hospitals were built and housed thousands of patients and employed thousands of individuals. At times, institutions played various roles including taking care of war veterans with "shell shock," family members from wealthy families who paid to have their loved ones taken care of, and the severely disabled. "Scientific" treatments evolved from hydrotherapy, lobotomies, dental and electric shock to the use of psychotropic medications, cognitive therapies, and other best practices known today aimed at recovery and preventing the need for inpatient treatment. Whereas the population of state institutions in the early to mid-20th century ranged in the one hundred thousands, the census today is roughly fifty thousand individuals.

Note: The following section is mostly excerpted and adapted from SAMHSA's *Funding and Characteristics of State Mental Health Agencies,* 2009 and 2007 editions.

In 2008, Iowa had approximately 150 adult residents in the state psychiatric hospitals at the start of the fiscal year. Patients per population (100k) were 6.8, as compared with a national average of 18. Average length of stay for adults was 53 days as compared with a national average of 170. Thus, the MHI's in Iowa play more of an acute care role than in many other states. In addition, 80.7% of children and adolescents were involuntarily admitted in FY 12 while those categorized as Adult Psych was 87.6%, and 70.4% for the Adult Dual program.

Most states use their state psychiatric hospitals to serve adults, elderly consumers, and forensic patients. Patient demographics are increasingly toward treating those with forensic involvement or who require a longer inpatient stay and serving individuals without forensic status in community settings or local acute care inpatient settings as needed. Nationally, nearly one-third of all consumers in state hospitals were involuntarily criminally committed. Since 1993, state psychiatric hospital expenditures have increasingly been applied to forensic services. In 2006, 2% of Iowa's MHI population had a forensic status whereas the average across the country was 32%. Voluntary admissions into state hospital level settings are in decline, though Iowa has a relatively high number of voluntary admissions (21%) as compared with some states with fewer than 5% of admissions being voluntary (e.g. New Jersey, Mississippi, Montana, Nebraska, Nevada, New Hampshire, Tennessee, Utah and others). Several factors may contribute to this including geography in rural states and lack of funding for community-based alternatives.

As State Mental Health Authorities (SMHA) continue to reduce the size and presence of state psychiatric hospital beds and more frequently treat consumers in community-based treatment settings, funding for psychiatric hospitals continues to decline. In FY 2001, 63 percent of SMHA funds were devoted to community mental health systems. In FY 2007, SMHAs expended over 71 percent of their funds on community mental health services, whereas state psychiatric hospital inpatient services represented only 27 percent of SMHA resources.

Nonetheless, the cost of operating state hospitals is mostly paid for by states and counties, and is expensive. The federal government, through CMS, continues to refrain from financial participation in large inpatient and community-based congregate care settings, known as Institutions for Mental Diseases (IMD). In 2008, the average expenditures per patient day for civil status adults were $566.80, or roughly $207,000 annually. This number may actually be higher since many SMHAs do account for fringe benefits in their cost estimates since these are often the responsibility of state Treasury departments.

Twenty-six SMHAs indicated that they either have closed, or are planning to reorganize, downsize, or close, a total of 44 state hospitals. Four states have closed a total of seven facilities in the past 2 years, and five states are currently planning to close one or more state psychiatric hospitals. Rather than eliminate state-operated inpatient psychiatric services altogether, many states are opting to reorganize their systems. Of the 26 SMHAs with plans to reorganize, the most frequently cited activities include closing hospital wards (58 percent), significantly reorganizing within one or more state hospitals (46 percent), downsizing one or more hospitals (42 percent), and consolidating two or more hospitals (23 percent). Eleven SMHAs are replacing old state psychiatric hospitals with new hospitals.

Olmstead:

Several challenges emerge as states seek to redefine the roles of state psychiatric hospitals and other service providers, and rebalance the use of resources. There are many public opinions about what's best for consumers and where they should be served and economic and employment concerns for local communities. Paramount is the need to keep civil rights and fact based dialogue regarding the prudent use of taxpayer dollars at the forefront of all discussions. States, and in many instances, counties, will also continue to play a role in ensuring the availability of safety net services.

While the availability of inpatient treatment, both longer and shorter term, will be necessary in the foreseeable future, it is increasingly accepted that smaller, more integrated community-based settings over large congregate settings, both inpatient and community-based, are more preferable to consumers, produce better outcomes and are more economical to states. However, rebalancing systems is complex and requires changes in thinking, commitment to ensure civil rights of consumers, and creative funding strategies. Iowa will need to grapple with the design of its residential/housing continuum, how it should be funded, and what role larger facilities should play in the mental health system.

What is clear is that states are increasingly facing litigation from the US Department of Justice and/or statewide protection and advocacy organizations, using the US Supreme Court *Olmstead* decision, to force Development of smaller, more integrated housing and services options for people with mental illness and other disabilities. Though the Supreme Court decision was made in 1999, Olmstead efforts appear to have accelerated in the past few years. For example, New York lost a case last year for having too many people living in "adult homes,[1]" large board and care facilities that provided little treatment and community integration. New York also recently settled a lawsuit aimed at overutilization of nursing homes for people

[1] This case is under appeal.

with mental illness, and is geared toward facilitating the movement of people into more integrated housing options[2]. Illinois recently settled a case where it was asserted by the Illinois ACLU and other advocacy organizations that they had too many people living in nursing homes[3].

As stated above, CMS continues to refrain from financial participation in large inpatient and community-based congregate care settings, known as Institutions for Mental Diseases (IMD), and is focusing its efforts on providing Medicaid reimbursement opportunities in smaller settings. Thus, states and counties remain the primary payer for larger settings whereas the federal government will participate financially in smaller settings enabling many states to serve more people at a fraction of the costs. CMS has developed various funding strategies to support community integration. Among these include the use of optional services such as the 1915(i) (Note: Iowa has a 1915(i) state plan option), rehabilitation option services, and Money Follows the Person. More recently, the care coordination features in the Health Homes option are likely to lead to positive outcomes. CMS will not reimburse for services provided in residential programs with more than 16 beds.[4]

While Iowa tends to have fewer patients per one hundred thousand residents in its Mental Health Institutes, its percentage of civilly committed and voluntary patients is higher than many other states, and its percentage of those with forensic involvement is lower than the national average. It should be anticipated that as those collectively involved in the mental health system (i.e. providers, courts, police) engage and divert people away from the criminal justice system to the mental health system, there could be added pressure for inpatient settings in lieu of corrections. This may ultimately present an issue of adding additional beds or redefining the target population of who is served in the continuum of inpatient settings in Iowa.

Questions for Discussion:

1. What should the role of the Mental Health Institutes be? Long term? Short term?
2. Who should be served there?
3. Are there other inpatient settings that should be developed or expanded?
4. In funding and developing community-based residential options (Crisis Residential, Sub-acute, Group, Independent Living), what principles should guide the development or modification of standards?
5. What other state agencies should play a role in the development of community-based residential options for consumers?

[2] Joseph S. et al. v. Hogan
[3] Williams v. Quinn
[4] There are some exceptions. CMS will pay for services for those under 21 or over 65 years of age. CMS may also pay for services if the facility has more than 16 beds, but less than 50% of the residents have a mental illness or substance use disorder.

References:

Substance Abuse and Mental Health Services Administration, *Funding and Characteristics of State Mental Health Agencies, 2009.* HHS Publication No. (SMA) 11-4655. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, Md: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.